in Medline, EMBASE, International Pharmacological Abstracts and the Cochrane Collaboration. Two independent reviewers identified the abstracts, selected the full articles, and extracted the data. Odds ratios and weighted means differences were calculated. Random effects models were employed in the analyses with RevMan v.5.0 software. **RESULTS:** A total of 1253 studies were reviewed and 10 trials were finally selected where parecoxib was assessed in hip, knee and spine surgeries, as well as bunionectomy. In 6/10 studies, parecoxib 40 mg showed a higher global treatment evaluation against placebo (OR 0.20; 95%CI 0.13–0.31) and improvements in the consuming rescue drugs rate (OR 0.18; 95%CI 0.07–0.47), as well as in cumulative morphine consumption, and pain intensity ($p < 0.001$). In three studies, parecoxib was as effective as ketorolac, paracetamol, metamizole or morphine. Frequency of AE was similar between parecoxib and placebo or other drugs. Parecoxib 20 mg showed less postoperative fever than placebo (OR 0.46; 95%CI 0.24–0.89). **CONCLUSIONS:** Parecoxib 40 mg is an effective and safe analgesic option during the first hours of the postoperative period in orthopedic surgeries.

SYSTEMIC DISORDERS/CONDITIONS – Cost Studies

PSY6

IMPACT OF A PRIOR AUTHORIZATION FOR PREGABALIN ON HEALTH PLAN DRUG EXPENDITURES

Bazalo G[1], Weiss RC[2], Joshi AV[3]
[1]Managed Solutions, LLC, Conifer, CO, USA, [2]Managed Solutions, LLC, Randolph, NJ, USA, [3]Pfizer Inc., New York, NY, USA

OBJECTIVES: The purpose of this study was to model the economic impact of a prior authorization (PA) requirement for pregabalin from a US health plan perspective. **METHODS:** An Excel-based model was developed to simulate two hypothetical scenarios: 1) A health plan in which a PA is placed on pregabalin, and 2) a health plan in which there is no PA. In both scenarios, a mix of brand and generic products based on secondary prescription data from IMS was assumed dispensed to patients who did not receive a pregabalin prescription or who were denied pregabalin in the PA process. PA rejection rates were obtained from a PBM database analysis. The pregabalin prescribing rate was set to 10.3% in both the PA and no PA scenarios, with a denial rate of 50% in the PA scenario. The model incorporated the drug wholesale acquisition cost (WAC) or the federal upper limit for generics, cost of PA administration (published literature), and copayments, in each scenario for a cohort of 1000 patients over a one-year period. Sensitivity analyses were carried out with various PA administration costs and product mixes for the pregabalin alternatives. **RESULTS:** The difference in costs between the two scenarios was 0.4% ($886,000 for the PA scenario vs. $889,000 for the "no PA" scenario). Setting the PA administration cost to zero, the difference in drug acquisition costs alone was 0.8%. When the product alternatives to pregabalin were replaced with gabapentin only, the difference in drug acquisition costs alone was 3.4%. **CONCLUSIONS:** Based on the actual mix of products used across pregabalin indications, a PA on pregabalin has a minimal impact on total costs to the health plan. The difference in drug acquisition costs was less than 1% for a mix of product alternatives based on audited prescription data.

PSY7

ECONOMIC VALUE OF LIDOCAINE PATCH 5% VS. GABAPENTIN OR PREGABALIN IN MEDICAID PATIENTS WITH POST HERPETIC NEURALGIA

Ivanova JI[1], Puenpatom RA[2], Kirson NY[3], Birnbaum HG[3], Wei R[3], Kantor E[3], Summers K[2]
[1]Analysis Group, Inc., New York, NY, USA, [2]Endo Pharmaceuticals, Inc., Chadds Ford, PA, USA, [3]Analysis Group, Inc., Boston, MA, USA

OBJECTIVES: Compare direct health care resource utilization and costs of post herpetic neuralgia (PHN) patients initiating lidocaine or gabapentin/pregabalin. **METHODS:** Patients with PHN diagnosis (ICD-9-CM: 053.12, 053.13 or 053.19) or herpes zoster diagnosis (ICD-9-CM: 053.0x, 053.10, 053.11, 053.2x, 053.7x-053.9x) and at least 30 days PHN-related treatment were identified from Medicaid claims data from Florida, Iowa, Missouri, and New Jersey, 1999–2007. Patients initiated monotherapy with lidocaine or gabapentin/pregabalin after PHN diagnosis, had continuous eligibility 6 months before (baseline) and 6 months after (study period) the medication index date, and were at least 18 years old. Lidocaine patients were matched to patients initiating gabapentin/pregabalin on age and propensity to initiate lidocaine based on baseline characteristics. Study period direct resource use and costs, calculated as reimbursements to providers for medical services and prescription drugs, were compared between the two matched groups using univariate analysis. **RESULTS:** After matching on age and propensity to initiate lidocaine, baseline characteristics (such as age, comorbidities, prior resource use and direct costs) were well-balanced between the treatment groups. Matched patients were on average 61 years old, 73% were women, approximately 24% had a mental disorder diagnosis, and 55% had other painful conditions during the baseline period. Among matched lidocaine (n = 306) and gabapentin/pregabalin (n = 306) patients, there were no statistically significant differences in study period treatment with tricyclic antidepressants (16.0% in both groups), analgesic medications (86.6% vs. 86.9%), and other PHN-related treatments (6.9% vs. 6.2%) such as DREZ lesions, epidural steroids and nerve blocks. No statistically significant differences were found in resource use, average total health care costs per patient ($8,740 vs. $8,630, $P = 0.880$) and PHN-related costs ($1,046 vs. $1,067, $P = 0.908$) between matched lidocaine and gabapentin/pregabalin patients. **CONCLUSIONS:** PHN patients treated with lidocaine cost no more than patients treated with gabapentin or pregabalin over the 6-month study period.

PSY8/CM3

PERSISTENCE WITH INFLIXIMAB MAINTENANCE THERAPY DECREASES HOSPITALIZATIONS IN PATIENTS WITH ULCERATIVE COLITIS

Waters H[1], Carter C[1], Smith P[2], Smith D[3]
[1]Centocor Ortho Biotech Services, LLC, Horsham, PA, USA, [2]IMS Health, Watertown, MA, USA, [3]IMS Health Incorporated, Watertown, MA, USA

OBJECTIVES: To assess maintenance treatment patterns of infliximab (IFX) in ulcerative colitis (UC) and the impact of persistence on UC-related hospitalization. **METHODS:** A retrospective claims analysis using the IMS LifeLink™ Health Plan Claims Database between September 1, 2004 and March 31, 2009 was conducted. The index date was defined as the first claim for IFX between September 1, 2005 and January 1, 2008. Continuous enrollment for 12 months prior and 14 months after the index date was required. Patients were required to have ≥2 claims with an ICD-9 diagnosis code for UC pre-index and be ≥18 years at index. Patients with selected other inflammatory diseases and those undergoing colectomy within 12 weeks of the index date were excluded. Patients with ≥1 infusion following day 56 post index were considered to have maintenance therapy. Hospitalizations were compared to the group of patients with induction infusions only. Within the maintenance treatment group, therapeutic persistence was defined as a medication possession ratio (MPR) of ≥80%; this group was compared to those without therapeutic persistence (<80% MPR). **RESULTS:** A total of 420 patients were included in the analyses; mean (SD) age = 43.9 (14.1) years; 47.9% female; mean (SD) 6.08 (2.49) IFX infusions; 84.3% (n = 354) continued to maintenance therapy. Maintenance patients incurred fewer UC-related hospitalizations (0.12 vs. 0.32), associated costs ($3118 vs. $8610) and had shorter average lengths of stay (ALOS; 8.9 vs. 11.65 days) than induction-only patients. Among maintenance patients, those demonstrating therapeutic persistence (n = 202; 57.1%) incurred fewer UC-related hospitalizations (0.03 vs. 0.22) and associated costs ($423 vs. $6678), and had shorter ALOS (6.67 vs. 9.71 days) than those without therapeutic persistence. **CONCLUSIONS:** Persistent maintenance treatment with IFX is associated with fewer UC-related hospitalizations, lower inpatient costs, and shorter ALOS among patients with UC. Physicians should monitor patients with UC to ensure appropriate IFX maintenance therapy paradigms are followed.

PSY9

THE DIRECT COSTS OF INFLAMMATORY BOWEL DISEASE: EVIDENCE FROM UNITED STATES NATIONAL SURVEY DATA

Lofland J[1], Naim A[1], Rizzo J[2], Gunnarsson C[3], Chen J[4], Waters H[1]
[1]Centocor Ortho Biotech Services, LLC, Horsham, PA, USA, [2]Stony Brook University, Stony Brook, NY, USA, [3]S2 Statistical Solutions Inc, Cincinnati, OH, USA, [4]College of Staten Island/CUNY, Staten Island, NY, USA

OBJECTIVES: To quantify individual and national estimates of the direct costs of inflammatory bowel disease (IBD), Crohn's disease (CD), and ulcerative colitis (UC), using national survey data. **METHODS:** This was a retrospective study using 1996–2006 data from the Medical Expenditure Panel Survey (MEPS). Individuals self-reported health conditions were mapped to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic codes. Individuals with an ICD-9-CM diagnostic code of 555.x (CD) or 556.x (UC) were categorized as having IBD. Health care services included prescriptions, inpatient, outpatient, emergency room, office, and home health services. Health care costs were collected for the health care services. Out-of-pocket (OOP) costs were the portion of individuals' total payments for the health care services. To estimate the health care and OOP costs, an ordinary least squares model was performed. Individuals with and without IBD were compared. **RESULTS:** There were 411 individuals with IBD (mean age = 47.7 years; 57% Female), and 161,953 individuals without IBD (mean age = 48.2 years; 58% Female). The annual per capita health care costs for individuals with IBD were more than double those for individuals without IBD ($11,759 vs. $5,700; $p < 0.001$). The annual per capita OOP costs for individuals with IBD were also almost twice those of individuals without IBD ($2,082 vs. $1,147; $p < 0.001$). When combining health care and OOP costs, IBD increases the total annual per capita direct costs by $7,021. The US national annual estimates of the health care, OOP, and total direct costs secondary to IBD are $2.8 billion, $0.4 billion, and $3.2 billion respectively. **CONCLUSIONS:** The direct costs associated with IBD are substantial not only to health care payers but to patients as well. The extent to which appropriate and early diagnosis and treatment of IBD reduce the total health care costs for individuals with this disease should be examined.

PSY10

THE DIRECT MEDICAL COSTS OF PSORIASIS: EVIDENCE FROM UNITED STATES NATIONAL SURVEY DATA

Lofland J[1], Rizzo J[2], Gunnarsson C[3], Chen J[4], Waters H[1]
[1]Centocor Ortho Biotech Services, LLC, Horsham, PA, USA, [2]Stony Brook University, Stony Brook, NY, USA, [3]S2 Statistical Solutions Inc, Cincinnati, OH, USA, [4]College of Staten Island/CUNY, Staten Island, NY, USA

OBJECTIVES: To quantify individual and national estimates of the direct medical costs of psoriasis (PsO) and similar disorders, using national survey data. **METHODS:** This was a retrospective study using 1996–2006 data from the Medical Expenditure Panel Survey (MEPS). Individuals' self-reported current health conditions were mapped to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic codes. Individuals with an ICD-9-CM diagnostic code of 696.xx were categorized as having PsO. Health care services included prescriptions, inpatient, outpatient, emergency room, office, and home health services. Health care costs